Title 24-A: MAINE INSURANCE CODE

Chapter 75: RURAL MEDICAL ACCESS PROGRAM

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§6301. SHORT TITLE

This chapter is known and may be cited as the "Rural Medical Access Program." [1989, c. 931, §5 (NEW).]

SECTION HISTORY
1989, c. 931, §5 (NEW).

§6302. PURPOSE

The purpose of this chapter is to promote perinatal services in underserved areas of the State. [1991, c. 734, §2 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §2 (AMD).

§6303. DEFINITIONS

For purposes of this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1989, c. 931, §5 (NEW).]

1. **Insurer.** "Insurer" means any insurer authorized to transact insurance in this State and any insurer authorized as a surplus lines insurer pursuant to chapter 19.

[1989, c. 931, §5 (NEW) .]

2. **Physician's employer.** "Physician's employer" means any hospital, health care facility, clinic or other entity that employs a physician and pays for or otherwise provides professional liability insurance for the physician.

[1989, c. 931, §5 (NEW) .]

2-A. **Program.** "Program" means the Rural Medical Access Program.

[1991, c. 734, §3 (NEW) .]

3. **Self-insured.** "Self-insured" means any physician, hospital or physician's employer insured against the physician's professional negligence or the hospital's professional liability through any entity other than an insurer as defined in subsection 1. For purposes of this chapter, a physician, hospital or physician's employer that does not purchase insurance is considered self-insured.

[2005, c. 122, §1 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §3 (AMD). 2005, c. 122, §1 (AMD).

§6304. ASSESSMENTS AUTHORIZED

To provide funds for the Rural Medical Access Program, insurers may collect pursuant to this chapter assessments from physicians licensed and practicing medicine in this State and hospitals and physician's employers located in the State. [2005, c. 122, §2 (AMD).]

1. **Assessment from policyholders and self-insureds.** With respect to professional liability insurance policies for physicians and hospitals issued on or after July 1, 1990, each insurer shall collect an assessment from each policyholder. With respect to professional liability insurance for self-insureds issued on or after July 1, 1990, each self-insured shall pay an assessment as directed by the superintendent. The superintendent shall determine the amount of the assessment in accordance with this chapter. Notwithstanding any provision of law, assessments made and collected pursuant to this chapter do not constitute premium, as defined in section 2403, for purposes of any laws of this State relating to taxation, filing of insurance rates or assessment purposes other than as expressly provided under this chapter. The assessments are considered as premium only for purposes of any laws of this State relating to cancellation or nonrenewal of insurance coverage and the determination of hospital financial requirements under Title 22, chapter 107.

[1989, c. 931, §5 (NEW) .]

2. **Required support.** Every insured and self-insured physician, hospital, and physician's employer shall support the Rural Medical Access Program as provided in this chapter. Any physician, hospital or physician's employer that fails to pay the assessment required by this chapter is subject to a civil penalty not to exceed $2,000, payable to the bureau, to be recovered in a civil action.

[1989, c. 931, §5 (NEW) .]

3. **Assistance from boards and Department of Health and Human Services; insure through other means.** The Board of Licensure in Medicine and the Board of Osteopathic Licensure shall assist the superintendent in identifying those physicians who insure against professional negligence by means other than through insurers defined in section 6303. The Department of Health and Human Services shall assist the superintendent in determining the insuring entity for any licensed hospital or physician's employer, in identifying those hospitals and physician's employers that insure against professional negligence by means other than through insurers defined in section 6303 and in identifying the individual or entity who makes the insurance payment for each physician.

[1993, c. 600, Pt. B, §§21,22 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

4. **Determination of assessments paid.** After review of the records provided by the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Department of Health and Human Services, Division of Licensure and Certification, and the assessment receipts of the malpractice insurers, the superintendent shall determine those physicians, hospitals and physician's employers that have paid the required assessments.

[2005, c. 122, §3 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §4 (AMD). 1993, c. 600, §§B21,22 (AMD). 2003, c. 689, §B6 (REV). 2005, c. 122, §§2,3 (AMD).

§6305. AMOUNT OF ASSESSMENT DETERMINED

1. **Determination of assessment based on anticipated savings.** The amount of the assessment is calculated as follows.

A. For policy years beginning on or after July 1, 1990, the superintendent shall determine the amount of the savings in professional liability insurance claims and claim settlement costs to insurers anticipated in each 12-month period as a result of the Medical Liability Demonstration Project established in Title 24, chapter 21, subchapter IX and reform of the collateral source rule. [1989, c. 931, §5 (NEW).]

B. The amount of the assessment for policy years beginning on or after July 1, 1990, but before July 1, 1991, is equal to the total of:

(1) One hundred percent of the first $250,000 of savings determined under paragraph A;

(2) No portion of the savings determined under paragraph A that exceeds $250,000 but does not exceed $500,000; and

(3) Fifty percent of the portion of the savings determined under paragraph A that exceeds $500,000 but does not exceed $1,000,000. [1989, c. 931, §5 (NEW).]

C. [2005, c. 122, §4 (AMD); T. 24-A, §6305, sub-§1, ¶ C (RP).]

D. [2005, c. 122, §5 (RP).]

E. Each insurer shall assess the surcharge against its insureds as a percentage of premium unless the superintendent prescribes a different basis by rule or order. [1989, c. 931, §5 (NEW).]

F. Every self-insured physician or physician's employer and every self-insured hospital shall remit the assessment required by this section to the principal writer of physicians malpractice insurance in this State. Remittance by self-insured physicians or hospitals may be made on their behalf by a self-insurer. The superintendent shall prescribe by rule a method to calculate and collect the assessment from self-insured physicians, hospitals and physicians' employers. [1989, c. 931, §5 (NEW).]

[2005, c. 122, §§4, 5 (AMD) .]

2. **Final evaluation of savings.**

[2005, c. 122, §6 (RP) .]

3. **Assessment rates; program fund balance.** For assessment years prior to July 1, 2006, the assessment is 1.25% of premium. For assessment years commencing July 1, 2006 and after, the assessment is 0.75% of premium unless adjusted pursuant to rules adopted in accordance with subsection 4. The assessment rate is intended to result in collections no greater than $500,000 per assessment year. The superintendent shall notify affected parties of any assessment rate adjustment and the effective date of that adjustment.

The program fund balance may be used to pay assistance to qualified eligible physicians in prior years for which there were insufficient funds. If all prior years' eligible qualified physicians have received assistance, any excess funds must be carried forward to subsequent plan years as part of the program fund balance. Excess funds must be applied first to the assessment year commencing July 1, 1998 and then to each successive assessment year.

For the purposes of this section, "program fund balance" means the total funds collected in excess of assistance paid for all years.

[2013, c. 170, §1 (AMD) .]

4. **Establishment of assessment rate by rule.** The superintendent may adopt rules pursuant to section 6311 establishing an assessment rate or a methodology for calculating an assessment rate designed to provide an adequate and reliable funding source for the program and allow for the orderly and prudent drawdown of any long-term fund balance in excess of reasonable program needs. The assessment rate may not result in

expected collections exceeding $500,000 per assessment year and may not exceed 0.75% of premium unless the program fund balance is $50,000 or less, in which case the assessment rate must be set to a higher rate but may not exceed 1% of premium.

[2013, c. 170, §2 (NEW) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1995, c. 570, §10 (AMD). 1999, c. 668, §113 (AMD). 2005, c. 122, §§4-7 (AMD). 2013, c. 170, §§1, 2 (AMD).

§6306. FUNDS HELD BY INSURERS

Insurers shall invest assessments collected subject to chapter 13. Interest earned on investments must be credited to the Rural Medical Access Program. [2005, c. 122, §8 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 2005, c. 122, §8 (AMD).

§6307. QUALIFICATIONS FOR PREMIUM ASSISTANCE

1. **Eligibility qualifications.** A physician is a qualified physician eligible to participate in the program if that physician:

A. Is licensed to practice medicine in the State; [1989, c. 931, §5 (NEW).]

B. Accepts and serves Medicaid patients; [1989, c. 931, §5 (NEW).]

C. Provides complete obstetrical care for patients, including prenatal care and delivery, provided that physicians in an underserved area without a facility for obstetrical delivery are still eligible if they provide only prenatal care and have referral agreements for delivery with a physician meeting the requirements of paragraphs A and B; and [1989, c. 931, §5 (NEW).]

D. Practices at least 50% of the time in areas of the State that are underserved areas for obstetrical and prenatal medical services as determined by the Department of Health and Human Services. [2015, c. 1, §31 (COR).]

The Commissioner of Health and Human Services shall determine those physicians who meet the requirements of this subsection. The commissioner shall adopt rules, pursuant to the Maine Administrative Procedure Act, determining underserved areas with respect to obstetrical and prenatal care. "Underserved areas" includes medically underserved areas, health manpower shortage areas and other priority areas determined by the commissioner. The commissioner may adopt rules pursuant to the Maine Administrative Procedure Act defining the scope of services that must be provided to meet the requirements of paragraphs B and C and the method of prioritizing underserved areas for purposes of distribution of the funds authorized by section 6308.

[2015, c. 1, §31 (COR) .]

2. **Ineligible if premium owed.** Any physician or physician's employer who owes premiums to any insurer for any policy year prior to the year that participation in the program is sought is not eligible to participate.

[1991, c. 734, §5 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §5 (AMD). 2003, c. 689, §B7 (REV). RR 2015, c. 1, §31 (COR).

§6308. FUNDING OF THE PROGRAM

The amount of funds available for the program is determined as follows. [1991, c. 734, §5 (AMD).]

1. **Available funds.** The amount available for the program for policy years beginning on or after July 1, 1990, but before July 1, 1991, is 1/2 of the amount of the assessment determined under section 6305 for that year. For policy years beginning on or after July 1, 1991, the Bureau of Insurance shall determine the amount available, except that the amount may be no less than the assessment determined for that year.

[1991, c. 734, §5 (AMD) .]

2. **Determination of participants in the program.** The superintendent shall apply the standards of prioritization adopted by the Commissioner of Health and Human Services to determine the physicians who are eligible for the program. The funding available for each qualified physician is the amount equal to the difference between the physician's medical malpractice insurance premiums with obstetrical care coverage and the physician's premiums without obstetrical care coverage; however, the funding must be at least $5,000 but may not be more than $15,000 as determined by the superintendent. Program payments must be made to the individual or entity paying the medical malpractice premium for the qualified physician.

[2005, c. 122, §9 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §5 (AMD). 2003, c. 689, §B7 (REV). 2005, c. 122, §9 (AMD).

§6309. INTERCORPORATE TRANSFERS

The superintendent may order intercorporate transfers of funds to balance assessments and program payments on an equitable basis among insurers and to provide for payments to eligible self-insureds. [1991, c. 734, §5 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §5 (AMD).

§6310. APPEALS

1. **Assessments.** Physicians, hospitals and physicians' employers aggrieved by an insurer's application of the assessment provided for in this chapter may request a hearing before the superintendent. The hearing must be held in accordance with chapter 3, the Maine Administrative Procedure Act and procedural rules of the bureau.

[1989, c. 931, §5 (NEW) .]

2. **Eligibility.** Physicians aggrieved by an eligibility determination by the Department of Health and Human Services under section 6307 may request a hearing under the Maine Administrative Procedure Act.

[1989, c. 931, §5 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 2003, c. 689, §B6 (REV).

§6311. RULES

The superintendent and the Commissioner of Health and Human Services may adopt rules in accordance with the Maine Administrative Procedure Act to carry out this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2013, c. 170, §3 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 2003, c. 689, Pt. B, §7 (REV). 2013, c. 170, §3 (AMD).